DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

DBHDD REQUEST FOR CONVERSION FORM

INSTRUCTIONS FOR CONVERSION FORM

This form is used to update provider information maintained in the Department of Behavioral Health and Developmental Disabilities provider system regarding conversion of a Personal Care Home (PCH) or Community Living Arrangement (CLA) to a Host Home. This form is to be used only if the home is licensed and has an **ACTIVE** Medicaid provider number for Community Residential Alternative (CRA) services for the site being converted. The Personal Care Home or Community Living Arrangement must be currently operating in a sub-contracting relationship with the provider requesting the conversion. **The Host Home provider must not be the owner of another host home or licensed home.**

In addition to the Conversion Request Form, the following must also occur in the following order:

1. **The contracting DBHDD provider must complete and submit the following to the Office of Provider Network Management (PNM):**
   a. **The Conversion Request Form signed by the contracting DBHDD provider (agency), licensed home provider and DD Regional Services Administrator or designee.**
   b. **A copy of the current PCH or CLA license.**
   c. **Host Home Study with all of the required documents indicated in the DBHDD Host Home (Life Sharing) Policies and Procedures.**

2. **Within 7 business days of receiving the documents listed in #1, PNM will review the documentation. If they are adequate, PNM will request a Site Inspection from the Regional Office. The site Inspection must be completed within 2 weeks of the notification date and results forwarded to PNM by the Regional Office.**

3. **Within 7 business days of receiving notification from the Regional Office that the site meets the DD Waiver requirement, PNM will notify the Regional Office, the provider and DCH, that the license type has changed from a Licensed Home to a Host Home. A new provider number will not be issued.**

4. **If approved, the owner of the Personal Care Home or Community Living Arrangement home must surrender the license to Healthcare Facility Regulation (HFR) within 7 business days of notification by PNM. The enrolled provider is responsible for submitting documentation (Surrender letter from HFR) to PNM indicating that the license has been surrendered. If documentation is not received within 14 business days, DBHDD Contracts office and DCH will be notified for further corrective action.**

Instructions:

Check the type of change being reported (CLA or PCH).

1. **Current Provider Identification (Required):**
   Complete provider's (agency's) business name as it is currently on file with DBHDD.

2. **Licensed Home Information (Required):**
   Complete the name and address listed on the CLA or PCH license**.** List the telephone number of the licensed home as well as the current **Georgia Medicaid Provider Number** assigned to this home. Include the number of Individuals currently receiving DD Residential Waiver Services in the licensed home.

3. **Signatures (Required)**:
   The following parties must sign and date this form attesting to the accuracy of the requested change.
   - Current Provider
   - Licensed /Host Home Provider
   - DBHDD Regional Office

The contracting agency must agree to the attestation and all parties must sign this form in order for the change to be approved.

For questions regarding this form or enrollment requirements, contact the DBHDD Office of Provider Network Management at mhddad-serviceapps@dbhdd.ga.us

Return this form and attachments to:

Provider Enrollment Unit
Office of Provider Network Management
Department of Behavioral Health and Developmental Disabilities
2 Peachtree Street, Suite 23.247
Atlanta, Georgia 30303

OR Fax: 404-463-6678

Email: mhddad-serviceapps@dbhdd.ga.us

DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES

DBHDD REQUEST FOR CONVERSION FORM

To be completed by approved DBHDD providers requesting a Change from a Licensed Home to a Host Home

Type of Change (Select one)	**FROM** ☐ **Community Living Arrangement (CLA)** ☐ **Personal Care Home (PCH)**	**TO** **Life Sharing/Host Home**

1. Current Provider Information

Agency Name:

2. Licensed Home Information

CLA or PCH Name:		**Medicaid Provider Number:**	
Address:			
City:	**State:** **Georgia**	**Zip:**	**Region:**
Telephone:	**Number of Individuals residing in home currently receiving DD Residential Waiver services:**		

3. Licensed / Host Home:

- **I have requested the change of the above licensed home to a host home.**
- **I am not the owner of another licensed home, i.e. PCH or CLA home other than the one listed in this request.**
- **I do not have another home enrolled as a Host Home.**

Host Home Name (print):	
Host Home Signature:	**Date:**

4. Agency Attestation Statement:

- **I certify that I have examined the above information and that it is true, accurate and complete.**
- **I acknowledge that I am currently in a subcontracting relationship with licensed home noted above (#2).**
- **To the best of my knowledge the HH Provider does not operate or own another Personal Care Home (PCH) or Community Living Arrangement (CLA) other than the one listed in this request.**
- **I understand that any misrepresentation or concealment of information may result in denial of this request.**

Provider Name (print):	
Provider Signature:	**Date:**

5. Regional Office: I have reviewed the request and I support this change

Regional Services Administrator or Representative (print):	
Regional Services Administrator or Representative Signature:	**Date:**